counts *should* be obtained is, in our judgment, an open issue, as are so many aspects of anticoagulant therapy. Certainly, daily counts would detect thrombocytopenia. The critical issue is whether such a routine would prevent or modify the potential consequences of heparin-induced thrombocytopenia. Arguments could be mounted to support a negative or a positive answer. Future studies dealing with an "outcome analysis" of such a practice are needed and should provide an answer.

Dr. Conti's comments also are welcomed. We found no relationship between bleeding risk and the activated partial thromboplastin time (PTT). As noted in the paper, most studies have found the same lack of relationship. We also agree that judgments as to risk/benefit ratio are the key to proper decision-making in this and other areas of medicine. How one can assure that decisions are made this way is, of course, another matter. We hope that publication of our study is one step in that direction.

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On 'Opening Up' the Health Care System

TO THE EDITOR: Dr. Arthur Rivin's article in the March issue[1] is articulate and well-written. However, I patently disagree with his conclusions, and I am surprised that you concurred with him editorially.

The crux of the discussion is under his heading "4. Personal Freedom." Herein he blatantly states that health care is "too complex to expect even the most sophisticated and educated layman . . . to select the proper care . . . without state control of educational requirements." This is the typical elitist rationalization for usurping another's freedom via governmental regulation ("I'm only doing this for your own good . . ."). I do not need to enumerate further examples to this sophisticated readership of the many ways the statists and collectivists in our country have steadily eroded the rights of the individual.

Licensure simply creates a monopoly that is maintained by governmental force and involves them in every aspect of medical care. This does not work to the advantage of either the patients or the physicans. The patients desire competent, compassionate care at a "proper" price. Licensure does little to ensure any of this (witness residency training and board certification).

If delicensure occurred it would not take very long for all sorts of positive educational fallout to occur—for example, more medical programs in the community hospitals informing the public about advances and giving more exposure to the medical staff; community "consumer guides" to physicians listing their credentials, fees and the like and, yes, probably "testimonials," too; a greater number of medical educational programs on community television. And so on.

Let's learn from the mistakes of big business: These dinosaurs are afraid to compete anymore (what free enterprise?) so they form a liaison with government and regulate their competition out of existence, much to the chagrin of the consumer. We don't have to do this. Unlike the days of yore when our capability was mostly psychological support through prestigious mysticism we really can cure or help many of our patients. The radiant, gold-headed Aesculapian cane and top hat have been replaced by the white coat, voluminous medical literature and a burgeoning armamentarium. We do not have to be afraid to compete in the free market.

For a succinct but very complete discussion of this topic I urge interested readers to write Charles W. Johnson, MD, 7702 Louis Pasteur Drive, San Antonio, TX 78229, and ask him for his essay on medical licensure.

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REFERENCE

1. Rivin AU: 'Opening up' the health care system—Public protection and personal freedom (Commentary). West J Med 1982 Mar; 136:261-264